King County

Department of
Community and Human Services

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FINAL PROGRAM DESIGN
Veterans and Human Services Levy: 5.8
Promote Cross-Systems Coordination by Investing in Partnership for Health Improvement through Shared Information (PHISI)

1. Goal (overarching investment strategy)

The Veterans and Human Services Levy Service Improvement Plan (SIP) set a goal of increasing the effectiveness of resource management and evaluation (page 27 of the SIP).

2. Objective (specific investment strategy)

Develop a common data set for assessment of adults, youth and families seeking a range of housing, health and human services: Efforts to promote increased cross-systems coordination and service integration are hampered by the absence of standardized tools and data elements for collection of service needs data about adults, youth and families.

"Levy funds invested to develop a comprehensive approach to the assessment of need for clients entering a variety of systems, including community health clinics, can improve access to needed behavioral health and other services, prevent decompensation or serious illness, expedite communication, and minimize duplication of intake efforts across multiple systems. The Levy can support the use of these tools through training and contracts." (Veterans and Human Services Levy Service Improvement Plan, Page 28)

Procurement Plan Objectives

VHS Levy funds under strategy 5.8 will be used to facilitate the development of a regional Health Information Exchange (HIE). The HIE will be an interactive data repository that significantly improves services by collecting and sharing health and human service records between providers in order to reduce duplication and redundancy of testing and services. The target populations will be safety-net populations served by a wide variety of health and human service agencies in King County. The HIE system is in planning stages and moving towards rapid implementation using Economic Stimulus funds and other region resources.

The VHS Levy funds will be used to support the development of PHISI by funding a regional non-profit to manage two phases of development – initial project design and then project implementation. The funds will not be used to purchase the actual system solution but to support the technical project management and the procurement and implementation process – including seeking Federal Health Information Technology funds provided by the economic stimulus plan

The HIE project has been planned for over the last 12 months by regional stakeholders and titled the Partnership for Health Improvement through Shared Information (PHISI)

The initial PHISI Health Information Exchange will be built from, and informed by, the work of the VHS Levy funded High Utilizer Integrated Database project (strategy 2.1a.) The initial service partners will be similar to the High Utilizer project and the initial population of focus will be the same safety net populations from which the high utilizers of services are identified (discussed in Section #12)

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Strategy Overview – PHISI

The SIP identified a need for a coordinated approach to providing more effective and efficient care to populations that use multiple service systems. While the SIP describes this as a "common data set," recent advances in technology have greatly streamlined ways in which organizations can integrate all or portions of their data without requiring that everyone use the same system or agree on collecting data exactly the same way. Lessons learned from the High Utilizer Database Project have provided an understanding of the need for, and possibilities of, an ongoing interactive data collection system.

One area where service integration is highly relevant to the VHS Levy target population is in the health care system. The PHISI project design team proposes to strategically invest VHS Levy funds in supporting the implementation of a health information exchange (HIE) system that is currently being planned by a group of regional health and human service stakeholders. These funds will help position PHISI to secure significant federal stimulus and other funds dedicated to implementing and maintaining regional coordinated Health and Human Service Information Systems.

Vision: Improve coordination, efficiency, and quality of regional health care by implementing an interactive Health Information Exchange as a vehicle for sharing comprehensive individual health and human service records among coordinated health care and related service providers.

Objectives include:

1. Create a regional (King County) web-based Health Information Exchange (HIE) that allows participating health and human service programs to contribute and share the health information and human services records of safety-net clients they serve. An HIE would present health data in views that are useful to clinicians, case managers, patients and their advocates, analysts, evaluators, and other authorized users.

2. Use HIE data for a range of purposes, including: evaluate improvements in individual and population health; assess changes in use of emergency health services; improve coordination of care and reduce redundant services; support individuals in better managing their own care; identify homeless high utilizers for linkage to housing; and inform future development of needed regional health and human services.

3. Develop and implement a long term management strategy for the HIE to ensure improved health and human services to persons under 200% of Federal Poverty Level (FPL) throughout King County

3. Population focus

The PHISI Leadership Group has agreed to prioritize the first phase of HIE development to target information sharing on those in the safety net population who make frequent use of health system resources, and have involvement in multiple systems and environments of care. This population is consistent with the target population of the Veterans and Human Services Levy, with a significant proportion expected to be homeless, and some would be veterans. This population would include:

- Those making frequent use of hospital emergency departments;
- Those using King County Jail Health Services who have high acuity medical, mental health and/or substance abuse conditions;
- Those making frequent use of the Dutch Shisler Service Center (Sobering Center); and
- Those who are considered "high risk clients" among Medicaid fee-for-service population.

Relevant health information would likely be found in the data systems of selected hospitals, selected community clinics, selected long-term care organizations, jail health services, the sobering center, the mental health and substance abuse systems, DSHS, and veteran's health system. Because many in this population are homeless, linkage to data in the Safe Harbors Homeless MIS could also prove beneficial for care coordination.

See attached graphic for a depiction of the target population and likely data sources.

Eventually the PHISI HIE system will be expanded to allow for information sharing on all those living within King County who are:

- Uninsured and under 200% of FPL
- Underinsured and under 200% of FPL
- Covered by GAU
- Covered by Medicaid
- Covered by Medicare/Medicaid (dual eligible).

The size of this population is estimated by PHISI staff to be 304,103 individuals in King County, who account for about $714,645,435 in documented annual combined health care expenditures in the medical, mental health, substance abuse systems.

By initially designing the system around the subset of those who have the most complex health conditions and frequent use of health care, it ensures that the HIE would likely work for the broader population when later expanded. The initial focus will also allow PHISI to work with a smaller group of contributing data systems to get the HIE off the ground more quickly than would otherwise be possible, and avoid getting bogged down. Finally, the return on investment is expected to be highest among the high-need individuals who use multiple systems of care, making this a good place to start given the current economic situation.

4. Need or Risk Information

Our public services, hospital emergency departments, jails and psychiatric hospitals are inundated with individuals in crisis. Many are frequent users who have complex and chronic needs that cannot be met effectively or efficiently in these high-cost settings. Frequent users are often involved in several systems of care (primary and behavioral health, social services, criminal justice, and housing systems).

Increasingly service providers are pressed to eliminate redundant services, testing and avoid contradictory prescriptions and assessments. Patient medical histories are taken repeated times. Duplicated testing may be called for by each different health provider when an accurate patient health history is not readily available. Yet, despite these pressures a lack of centralized health information sharing keeps providers and policy makers in the dark as to how resources are being used by high need clients.

It is imperative that involved health and human service systems develop a coordinated, integrated, regional access to shared health information about our most needy clients.

Currently, some collaborative teams and data sharing agreements facilitate information exchange and referrals to an increasing number of housing and supportive programs funded by federal, state and local sources. However, the county lacks a centralized, coordinated means to access critical health and human services records.

With the assistance of the Levy funds, DCHS and local partners will be able to implement a King County Health Information Exchange that will meet all federal,

state and local confidentiality and privacy regulations and promote collaborative care coordination.

Affected populations include the following:

Users of emergency health services

- The 600 highest users of Harborview Medical Center's Emergency Department (ED) in 2005 accounted for ten percent of all emergency cases with almost 8000 emergency 'admissions.' Over a third of these high users were homeless. While approximately 10 percent had a primary diagnosis of mental illness or substance use, many more had these issues secondary to the primary medical concerns that prompted them to seek care.
- In recent years, other hospital emergency departments in King County have experienced increased numbers of persons with mental illness and chemical dependency problems. Many are not able to provide an accurate or complete description of their medical/mental health history affecting delivery of care and efficient use of assessment and testing resources.
- A 2004 national study of community hospital utilization by persons with mental health and/or substance abuse disorders indicated that adults with these problems accounted for a quarter of all hospital stays. Over two-thirds of these admissions were billed to government insurers (e.g., Medicaid/Medicare). Well over half were admitted after entering through emergency departments.

Homeless persons

- The incidence of homelessness in adults with co-occurring disorders receiving mental health treatment is 3 to 4 times the incidence of those without co-occurring disorders.
- The health department's Health Care for the Homeless Network (HCHN) contracts with community agencies to improve access and provide services for homeless and formerly homeless people. Services are provided in shelters, day centers, supportive housing facilities, and health centers. In 2006, a total of 21,438 persons were served by HCHN contractors and public health centers.
- Of this total, 57 percent of those served were people of color and 43 percent had no insurance coverage. Homeless people served were African American (23 percent), Hispanic or Latino (16 percent), Asian/Pacific Islander (7 percent), American Indian/Alaska Native (5 percent) or multiracial (5 percent).

Users of the justice system

- A six-year study conducted by University of North Carolina (UNC) researchers revealed that of the 20,200 King County individuals with serious mental illness receiving publicly funded mental health care:
    - 7,000 were jailed at least once;
    - Two-thirds were detained for 'minor' crimes (misdemeanors and non-violent felonies); a third was detained for violent felonies.

- Those committing minor crimes were predominately Caucasian males (73 percent); a quarter of them were African Americans.
- Those committing felonies were predominately Caucasian males (64 percent); a third of them were African Americans.

Other High-Risk or Uninsured Individuals and Families

Individuals and Families with health insurance have at least the opportunity to have a centralized health record, including referral capability (depending upon the insurer). Uninsured individuals have little ability to transport complete medical records unless there is an agreement between their multiple providers.

- King County's community health centers, public health centers, and other core safety net clinics served 127,258 low-income persons in 2006, including many homeless and high risk individuals and families. Of this total, 40 percent (n = 51,142) were not eligible for Medicaid or other coverage. The majority of uninsured were between 35-59 years (40 percent of uninsured) or 19-34 years (38 percent). The majority of uninsured adults were Latino (34 percent), white (33 percent), or Black / African American or East African (12 percent).

5. Total Dollars Available

Appendix D of the Service Improvement Plan (SIP) allocated $480,000 for Strategy 5.8 Common Data Set including:

$ 240,000 from Human Services funds
$ 240,000 from Veterans funds

6. Geographic Coverage

PHISI will eventual serve the King County regional health care system. Initial populations will be from throughout the county but most of the safety net programs are located in Seattle.

7. Program Strategy Description

VHS Levy funds will be used to support the development of PHISI in two phases – initial design and project implementation. VHS Levy funds will pay a regional Health Care non-profit to provide project management support to PHISI. The funds will not be used to purchase the actual system but to support the technical project management and support through the procurement and implementation process.

Contract with a regional Health Quality/Health Information System capable non-profit

The PHISI working group has reviewed governance models for the project. There are a number of stakeholders and potential partners including funders, city and County government departments and divisions, hospital ER's, community health clinics and human service providers. The working group and governing board has determined that with this many stakeholders, the optimal strategy for the implementation of the HIE

will be to select an experienced community based non-profit to coordinate procurement and implementation and provide support to working staff and the governing board. Working staff will identify a preferred provider and contract with them in the summer of 2009. Requirements for preferred provider include:

- An agency for whom the PHISI project closely aligns with its mission and purpose
- An entity that has the flexibility to approach the design and implementation of PHISI with flexibility and ability to respond quickly – most likely a 501 (c) 3
- Experience in staffing regional health care information technology initiatives or policy groups
- Experience and understanding of the current best practice in regional Health Information Technology, and current understanding of recent and near term initiatives
- Track record of successfully working with diverse regional health care stakeholders
- Capacity to rapidly ramp up and support the PHISI project

Project Management – Phase I staff the initial design and procurement process

A contract will be let with the preferred provider to manage the development of PHISI – under the guidance of a stakeholder governing board and working group. Phase I activities include

1. Staff and support the Governing board and two sub-groups – IT technical group, Client/ Service provider user group
   August 2009 – December 2010 $75,000

2. Sub-contract with a IT/Health Systems business consultant in summer 2009 to develop the project charter, implementation/procurement strategy and business and high level functional requirements
   August 2009 – October 2009 $35,000

3. Sub-contract with a Quality Assurance consultant to act as a third party and keep governing board apprised of project status, monitor project documentation, due diligence and adherence to IT QA and Project Management standards
   September 2009 – January 2011 $30,000

Phase II PHISI implementation and maintenance

Phase II activities, resources, and implementation strategies will be defined in the product provided by the business consultant. The potential use of Phase II -- 5.8 funding will be proposed in the Project Financing Plan. The VHS Levy project Phase II will include the following work of the preferred provider:

1. Manage the development and implementation of the PHISI financing proposal including applying for Federal stimulus funds; establishing user contracting fees and other leveraged resources as necessary.

2. Based upon the developed project charter, manage the procurement and implementation process for the IT solution determined by stakeholders.

3. Based upon guidance of the business plan and procurement process, contract with preferred PHISI vendor and manage the implementation contract on behalf of the governing board.

Allocation of funds

Phase I budget proportion will be based upon 75% Human Service funding, 25% Veterans Service funding. The proportion is based upon projected beneficiaries of the initial implementation of PHISI with its target populations of chronically homeless and high-utilizers of health and safety net services. Phase II sources and budget will be developed based upon the financial plan created in Phase I by the project consultant. The Financial plan will include attention on the use of Veteran Levy portion of funding. The Phase II request for Levy funding must demonstrate a direct veterans' benefit commensurate with the funds sought for Phase II.

	Human Services Levy	Veterans Services	Total Allocation
Phase I Request	$105,000	$35,000	$140,000
Phase II Allocation (determined based upon need established in PHISI Financial Plan)	$135,000	$205,000	$340,000
Total 5.8 SIP Allocation	$240,000	$240,000	$480,000

Project Governance

The PHISI project is a King County wide collaboration. It was begun through the initiative of United Way, King County Public Health, and King County Department of Community and Human Services. A PHISI governing board would be established to oversee the HIE's scope, policies, procedures, data sharing agreements, security and privacy compliance, financing, and evaluation. The governance structure continues to evolve to include an oversight board with representatives from the following stakeholders and policy makers:

City of Seattle.

Harborview / University of WA

United Way

Veterans Administration Puget Sound Health Care System – Seattle.

Public Health – Seattle & King County.

King County Department of Community and Human Services.

The project has been facilitated by significant contributions from members of a PHISI staff work group. This group has involved representatives from King County Department of Public Health; King County Office of Management and Budget; King County DCHS – Mental Health Division; King County DCHS – Community Services Division; United Way. The group was recently expanded to include City of Seattle Department of Human Services and Harborview Medical Center.

Initial working sub-committees have been formed as follow:

Clinician/Client Care committee – direct service providers and system users to establish requirements and represent client needs and issues in the PHISI development process

IT staff subcommittee – IT staff will develop technical standards, monitor QA, and coordinate IT application implementation

HIPAA Standards committee – legal and professional staff will develop and monitor patient confidential standards and protocols

8. Disproportionality Reduction Strategy

Homelessness, disability, poverty and poor health status affect minority populations to a greater degree than whites. According to Safe Harbors HMIS in 2008 over 55% of the homeless single adults served by HMIS participating programs were people of color.

The health department's Health Care for the Homeless Network (HCHN) contracts with community agencies to improve access and provide services for homeless and formerly homeless people. Services are provided in shelters, day centers, supportive housing facilities, and health centers. In 2006, a total of 21,438 persons were served by HCHN contractors and public health centers. Of this total, 57 percent of those served were people of color. Homeless people served were African American (23 percent), Hispanic or Latino (16 percent), Asian/Pacific Islander (7 percent), American Indian/Alaska Native (5 percent) or multiracial (5 percent).

King County's community health centers, public health centers, and other core safety net clinics served 127,258 low-income persons in 2006, also including many homeless and high risk individuals and families. Of this total, 40 percent (n = 51,142) were not eligible for Medicaid or other coverage. The majority of uninsured adults were Latino (34 percent), white (33 percent), or Black / African American or East African (12 percent).

It is well documented that racial and ethnic minorities receive lower-quality health care than white people. The structure of standard health systems themselves contribute to racial and ethnic disparities in health care (*Unequal Treatment*, Institute of Medicine, 2002). One of the primary goals of the current national-level movement toward investment in health information technology is the reduction of racial and ethnic health disparities.

Health information exchanges, for example, create the opportunity to analyze aggregate data from many sources, which can be used for quality improvement, research, and pursuit of funding. One can more readily identify, by racial and ethnic group, specific health issues where focused intervention is needed. And because some special population groups (such as homeless people) often use multiple providers across the health care system, health information exchange allows for better access to accurate, timely information for clinical decision making and for care coordination.

The PHISI project will allow policy makers to analyze patterns of service use, and length of time in the system by ethnicity and minority status. The data will tell the story about need – to ensure the right resources are available to overcome increased barriers present due to ethnicity. The HIE will be a tool to illuminate where the system or policy fails to serve populations effectively or appropriately.

7. Evidence-Based Practice and Cost Savings

According to the 2008 eHealth Initiative's Annual Survey of Health Information Exchange at the State and Local Level:

- A majority (69%) of the fully operational exchange efforts (29/42) report reductions in health care costs.
- About half (52%) of fully operational exchange efforts (22/42) report positive impacts on health care delivery.
- A majority (69%) of operational exchange efforts (29/42) report a positive financial return on their investment for their participating stakeholders.

Source: http://www.ehealthinitiative.org/HIESurvey/

9. Coordination/Partnerships

The PHISI project will be a King county wide collaboration governed by

City of Seattle.

Harborview / University of WA

United Way

Veterans Administration Puget Sound Health Care System – Seattle.

Public Health – Seattle & King County.

King County Department of Community and Human Services.

Data contributing participants will include initially (See Attachment B)

Community and public health centers

Hospital Emergency departments

MHCADSD

Safe Harbors HMIS

Veterans Administration Puget Sound Health Care System – Seattle.

Health Care for the Homeless

Dutch Shisler Sobering Center

King County Jail Health

Washington State Department Social and Health Services

10. Timeline

Phase I – Developing PHISI Business and Functional Requirements, and Project Charter
August 2009 – October 2009

Phase II – Secure resources, refine design, conduct procurement process for a vendor, coordinate user agreements, implement PHISI with safety net populations
October 2009-December 2010

Phase III – PHISI management and expansion to county-wide populations
January 2011 - ongoing

11. Funding/Resource Leverage

Funding is from the both the Veterans and Human Services funds. An ongoing PHISI HIE would be funded through:

1. Various local, private, and in-kind staffing resources that are in place and being assembled to support initial planning activities and business analyst consultant in 2009-2010.
2. HITECH stimulus funds secured to cover the implementation.
3. PHISI grant options for a private sector partnership that could help pay for technology solution support in initial years, so we can prove that the HIE generates the anticipated return on investment.
4. Long-term financing through health care system cost savings, national health IT resources, user fees and other funding streams.

At this early stage it is not possible to identify the cost of implementing and maintaining PHISI.

12. Coordination/Relationship with other VHS Levy Projects

The PHISI Health Information Exchange will ultimately be an information resource for all safety net populations. As envisioned, the project will build partially from the work being done under VHS Levy project **"***2.1 (a-1): Development of a triaged list of the homeless high utilizers of sobering, courts, jails and the health systems***".** The goal of that project is to develop a means to identify the homeless high utilizers of sobering, courts, jails and health systems. The project, housed in MHCADS Division, intends to identify IT strategies to create an integrated data base from which high utilizers could be identified and then referred to a system of coordinated care to reduce their involvement in jail, and use of expensive health system resources. The staff of the project have been working to develop a data collection strategy and a coordinated care strategy. The current goal is to have the initial high utilizer list and ongoing data collection strategy by fall 2009.

The PHISI leadership group has discussed "high utilizers" of health services as a potential initial target population around which to pilot information sharing, in a manner that could be expanded upon to the larger safety net population. The high utilizer project and its target population could be a place for the PHISI to pilot cross-system information sharing.

The PHISI project will incorporate the data collection solutions used by the High Utilizer project as a part of its design effort. The lessons learned will help create the broader, more comprehensive permanent data integration system of health information and medical records. The initial population of focus for PHISI is similar to the safety net populations of the High Utilizer Project. However, the longer term vision for PHISI includes: more comprehensive records; real time data sharing, a greater number of data contributing agencies; and region-wide participation serving all safety net individuals and families. In the future the PHISI HIE will in turn be able to provide the high utilizer project with the service records necessary to identify potential clients for services.